STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155756	A. BUILDING 01 B. WING	11/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENTRY MEADOWS	7843 W JEFFERSON BLVD FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 11/26/12 Facility Number: 004945 Provider Number: 155756 AIM Number: 200814400 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Coventry Meadows was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111)	K0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation. This facility respectfully requests a revisit on or after December 26, 2012.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and hard wired smoke detectors in the resident rooms. The facility has a capacity of 150 and had a census of 136 at the time of this survey. The facility was found in compliance with state law in regard to sprinkler coverage and smoke detector coverage. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/30/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3 Based on observation and interview, the facility failed to ensure 1 of 2 resident room corridor doors on the 400 hall closed and latched into the door frame. This deficient practice could affect 4 residents in the back smoke compartment of the 400 hall. Findings include: Based on an observation with the Maintenance Supervisor and the Environmental Supervisor on 11/26/12 at 1:05 p.m., the corridor door to resident room 416 failed to latch into the door frame. The Maintenance Director acknowledged the corridor door to resident room 416 failed to latch into the door frame at the time of observation. 3.1-19(b)	K0018	**K 018 NFPA 101 Life Safety Code Standard** It is the practice of this facility to ensure that all doors protecting corridor openings are provided with positive latching hardware. However, based on the alleged deficient practice the following has been implemented: **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** · The striker plate on the door of room 416 on 400-hall was replaced to ensure the door closed and latched into the doorframe. The striker plate was replaced on November 28 th , 2012. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** · All residents have the potential to be affected by the alleged deficient practice. · All resident room corridor doors will be tested prior to December 26 th to ensure they have positive latching hardware. **What measures will be put into place or what systemic changes will**	12/26/2012

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			you make to ensure that the deficient practice does not recur: · The striker plate on the door of room 416 on 400-hall was replaced to ensure the door closed and latched into the doorframe. The striker plate was replaced on November 28 th , 2012. · The Maintenance Director or Designee will check all resident room doors have positive latching hardware on or before December 26 th 2012. · The Maintenance Director/Designee will in-service all managers to monitor resident room doors to ensure they have positive latching hardware. In-service will be completed by 12/26/12. · The Maintenance Director is in charge of program compliance **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** · A CQI monitoring tool called Resident Room Doors will be utilized every week x 4, monthly x 3 and quarterly x 2. · Data will be collected by Maintenance Director/Designee and submitted to the CQI committee. If threshold of 100% is not met, an action plan will be developed. · Non-compliance with facility procedures may result in disciplinary action up to and including termination. **Completion**	

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			Date: 12/26/2012	

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K0025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one-hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels in approved frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 18.3.7.3, 18.3.7.5, 18.1.6.3 Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide a one hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice was not in a resident care area but could affect any number of staff. Findings include: Based on an observation with the Maintenance Supervisor and the Environmental Supervisor on 11/26/12 at 2:00 p.m., a sprinkler head in the rear dietary corridor was pulled up and away from the ceiling dry wall leaving a one half inch gap around the sprinkler	K0025	**K 025 NFPA 101 Life Safety Code Standard** It is the practice of this facility to ensure all ceiling smoke barriers are maintained to provide a one hour fire resistance rating. However, based on the alleged deficient practice the following has been implemented: **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** · The sprinkler head in the rear dietary corridor was repaired on December 10, 1012 to ensure there is no gap around the sprinkler head. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:**	12/26/2012

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	head. The Maintenance Supervisor confirm there was a one half inch gap around the sprinkler head at the time of observation. 3.1-19(b)		· All residents have the potential to be affected by the alleged deficient practice. · All sprinkler heads were checked on or before December 26 th to ensure no other gaps exist around sprinkler heads. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · The sprinkler head in the rear dietary corridor was repaired on December 10, 1012 to ensure there is no gap around the sprinkler head. . · All sprinkler heads be monitored by the Maintenance Director/Designee on an on-going basis to ensure there are no gaps between the sprinkler heads and the ceiling. · The Maintenance Director/Designee will in-service Maintenance Assistant on the sprinkler head monitoring by December 26, 2012. · The Maintenance Director is in charge of program compliance **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:**	

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			· A CQI monitoring tool called Sprinkler Head Gaps will be utilized every month x 3 and quarterly x 2. · Data will be collected by Maintenance Director/Designee and submitted to the CQI committee. If threshold of 100% is not met, an action plan will be developed. • Non-compliance with facility procedures may result in disciplinary action up to and including termination. **Completion date: 12/26/2012**	

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K0051 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection, or extinguishing system operation. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72, National Fire Alarm Code, and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 18.3.4, 9.6 Based on observation and interview, the facility failed to ensure 1 of 5 smoke detectors in the main kitchen was not installed where air flow would adversely affect the operation. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice was not in a resident care area but could affect any number of staff. Findings include: Based on observation with the	K0051	**K 051 NFPA 101 Life Safety Code Standard** It is the practice of this facility to ensure smoke detectors are not installed where air flow would adversely affect the operation. However, based on the alleged deficient practice the following has been implemented: **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** · The smoke detector in the main kitchen is scheduled to be moved on December 14, 2012 away from the air supply duct by at least 3 feet.	12/26/2012

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	Maintenance Supervisor and the Environmental Supervisor on 11/26/12 at 2:03 p.m., the main kitchen had a smoke detector located eighteen inches from a supply air duct. Measurements were provided by the Maintenance Supervisor at the time of observation. 3.1-19(b)		**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** · All residents have the potential to be affected by the alleged deficient practice. · All smoke detectors will be checked by maintenance staff on or before December 26, 2012 to ensure they have not been installed where airflow would adversely affect the operation. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:** · The smoke detector in the main kitchen is scheduled to be moved on December 14, 2012 away from the air supply duct by at least 3 feet. · All smoke detectors will be monitored on an on-going basis to ensure they have not been installed where airflow would be adversely affecting the operation. · The Maintenance Director/Designee will in-service Maintenance Assistant on the smoke detector locations and monitoring by December 26, 2012. · The Maintenance Director is in charge of program	

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			compliance **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** · A CQI monitoring tool called Smoke Detector Location will be utilized every month x 3 and every quarter x 2. · Data will be collected by Maintenance Director/Designee and submitted to the CQI committee. If threshold of 100% is not met, an action plan will be developed. · Non-compliance with facility procedures may result in disciplinary action up to and including termination. **Completion date: 12/26/2012**	

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K0062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on observation and interview, the facility failed to ensure the spray pattern for sprinkler heads 3 of 10 smoke compartments were unobstructed. LSC 9.7.5 requires all automatic sprinkler systems be inspected, tested and maintained in accordance with NFPA 25, Standard for the inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Section 2-2.1.2 states unacceptable obstructions to spray patterns shall be corrected. This deficient practice could affect any of the 33 of the 200 hall residents, residents in the New Energy Wellness Center with a capacity of 12 residents and 2 staff members. Findings include: Based on observation with the Maintenance Supervisor and Environmental Supervisor on 11/26/12 from 12:17 p.m. to	K0062	**K 062 NFPA 101 Life Safety Code Standard** It is the practice of this facility to ensure the spray pattern for sprinkler heads are not obstructed. However, based on the alleged deficient practice the following has been implemented: **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** · The sprinkler head in the New Energy Wellness Center closet was repaired on December 10 th , 2012 so as the spray pattern of the sprinkler head will not be obstructed. · The light fixture was moved away from the sprinkler head in the Maintenance Supervisor's office on November 28 th , 2012 so as the spray pattern of the sprinkler head will not be obstructed. · The light fixture was moved away from the sprinkler head in the 200 hall soiled utility room on November 28 th , 2012 so as the spray pattern of the sprinkler head will not be obstructed.	12/26/2012

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	1:58 p.m., the spray pattern for the following sprinkler heads were obstructed: a) the sprinkler head had been pulled above the ceiling drywall in the New Energy Wellness Center closet, b) one of two sprinkler heads were located within three inches of a ceiling light fixture in the Maintenance Supervisor's office, c) one of two sprinkler heads were located within five inches of a ceiling light fixture in the 200 hall soiled utility room. This was confirmed by the Maintenance Supervisor at the time of observations. Measurements were provided by the Maintenance Supervisor. 3.1-19(b)		**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · All residents have the potential to be effected by the alleged deficient practice. · All sprinkler heads will be checked by maintenance staff on or before December 26, 2012 to ensure their spray pattern of the sprinkler head will not be obstructed. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · All sprinkler heads will be monitored on an on-going basis to ensure their spray patterns will not be obstructed. · The Maintenance Director/Designee will in-service Maintenance Assistant on the sprinkler head locations and monitoring by December 26, 2012. · The Maintenance Director is in charge of program compliance **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:**	

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			· A CQI monitoring tool called Sprinkler Head Inspection will be utilized monthly x 3 and quarterly x 2. · Data will be collected by Maintenance Director/Designee and submitted to the CQI committee. If threshold of 100% is not met, an action plan will be developed. • Non-compliance with facility procedures may result in disciplinary action up to and including termination. **Completion date: 12/26/2012**	

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K0144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on record review and interview, the facility failed to ensure the load testing for 7 of 12 months indicated a load test was conducted under operating temperature conditions, minimum exhaust gas temperatures or not less than 30 percent of the nameplate rating for the diesel powered emergency generator set. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised under operating temperature conditions, maintains the minimum exhaust gas temperatures or not less than 30 percent of the EPS nameplate rating at least monthly, for a minimum of 30 minutes. Chapter 3-5.4.2 of NFPA 99 requires a	K0144	**K 144 NFPA 101 Life Safety Code Standard** It is the practice of this facility to ensure the generator is inspected weekly and exercised under load for 30 minutes per month. However based on the alleged deficient practice the following has been implemented: **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** · On December 19 th MacAllister Inc. will in-service the Maintenance Department on how to calculate the percentage of the nameplate rating the generator was picking up under load however it has been determined that it could not be load tested to meet State requirements. The facility then authorized MacAllister to perform an annual load bank test on the generator scheduled for December 19 th , 2012. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:**	12/26/2012

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COVENTRY MEADOWS	7843 W JEFFERSON BLVD FORT WAYNE, IN 46804

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	written record of inspection, performance, exercising period and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all resident in the facility. Findings include: Based on review of the "Monthly Load Test Log" with the Maintenance Supervisor and the Environmental Supervisor on 11/26/12 at 2:37 p.m., the generator test log showed a monthly load test for the past twelve months but the log indicated the generator was operating at less than 30 percent of the nameplate rating for the following months in 2012: January, February, March, June, July, August and October. The Maintenance Supervisor acknowledged the emergency generator did not operate at 30 percent or more of the nameplate rating for the aforementioned months. 3.1-19(b)		· All residents have the potential to be effected by the alleged deficient practice. · On December 12 th MacAllister Inc. in-serviced the Maintenance Department on how to calculate the percentage of the nameplate rating the generator was picking up under load however it has been determined that it could not be load tested to meet State requirements. The facility then authorized MacAllister to perform an annual load bank test on the generator scheduled for December 19 th , 2012. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:** · All load tests on the generator will meet the minimum requirements as set forth by Life Safety Code Standards. The load test for the generator will be an annual load bank test conducted by McCallister Inc. or designee. · Maintenance Director is responsible for program compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155756	A. BUILDING 01 B. WING	11/26/2012

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			· The Executive Director will ensure the annual load bank test is conducted to meet the life safety code requirements. · Non-compliance with facility procedures may result in disciplinary action up to and including termination. **Completion date: 12/26/2012**	

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K0147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords such as an extension cord was not used as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 2 of the 22 residents on the 400 hall. Findings include: Based on an observation with the Maintenance Supervisor and the Environmental Supervisor on 11/26/12 at 12:48 p.m., a light weight extension cord was plugged in providing power to a phone charger in resident room 410. The Maintenance Supervisor acknowledged an extension cord was providing power to a phone	K0147	**K 147 NFPA 101 Miscellaneous** It is the practice of this facility to ensure flexible cords are not used as a substitute for fixed wiring. However, based on the alleged deficient practice the following was implemented: **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** · The lightweight extension cord in room 410 was removed from the building. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** · All residents have the potential to be affected by the alleged deficient practice. · All rooms will be checked on or before December 26 th to ensure no flexible cords are being used as a substitute for fixed wiring. **What measures will be put into place or what systemic**	12/26/2012

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	charger in resident room 410 at the time of observation. 3.1-19(b)		**changes you will make to ensure that the deficient practice does not recur:** · All rooms will be monitored on an on-going basis to ensure no flexible cords are being used as a substitute for fixed wiring. · The Maintenance Director/Designee will in-service all managers on the prohibited use of flexible cords being used as a substitute for fixed wiring by December 26, 2012. · The Maintenance Director is in charge of program compliance **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** · A CQI monitoring tool called Flexible Wiring will be utilized weekly x 4, monthly x 3 and quarterly x 2. · Data will be collected by Maintenance Director/Designee and submitted to the CQI Committee. If threshold of 100% is not met, an action plan will be developed. · Non-compliance with facility procedure may result in disciplinary action up to and including termination. **Compliance date: 12/26/2012**	